



South Dakota Board of Nursing  
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115  
(605) 362-2760 ♦ Fax: 362-2768 ♦ [doh.sd.gov/boards/nursing](http://doh.sd.gov/boards/nursing)

CERTIFIED REGISTERED NURSE ANESTHETIST & CLINICAL NURSE SPECIALIST  
GENERAL INSTRUCTIONS FOR LICENSURE APPLICATION

Please follow instructions carefully to avoid delays in processing your application. If any of the information on your application is incorrect, incomplete or illegible, processing of the application may be delayed. You can expect that it will take 4 – 6 weeks before all forms are received by the Board office, upon receipt of all forms your application will be considered for approval. You will be notified in writing if additional information is required or that your application has been approved.

**Application and Fees**

1. Complete general application Form 1 and return to South Dakota (SD) Board of Nursing (BON) office.
2. The fee for licensure is \$100 and must accompany application. Fee payment should be in the form of a money order or check payable to SD Board of Nursing. Fees are non-refundable. If a Temporary Permit is also desired, see Temporary Permit below.

**Registered Nurse License**

1. You must have a current, valid, unencumbered SD RN license or temporary permit.
  - If not, complete RN Application for Licensure by Endorsement; [www.doh.sd.gov/boards/nursing](http://www.doh.sd.gov/boards/nursing)
2. *Or* – provide a copy of your current, valid, unencumbered compact RN license from your primary state of residence (where you hold a driver's license, pay taxes, and/or vote).
  - SD is a member of the Nurse Licensure Compact, for more information on the Nurse Licensure Compact see [www.ncsbn.org](http://www.ncsbn.org).

**Criminal Background Check**

1. Pursuant to SDCL 36-9-97, ARSD 20:48:03:01:01, and ARSD 20:48:05:01, each applicant for initial licensure is required to submit a full set of fingerprints with completed application to obtain a state and federal criminal background check.
2. Please contact the South Dakota Board of Nursing to request a criminal background check packet.
3. The fingerprint cards you receive from the SD BON **must** be the cards you use for fingerprints, since specific agency data are pre-printed on them.
4. Contact your local law enforcement agency for fingerprinting.
5. Send to the SD BON office your completed fingerprint cards and a separate check or money order for \$43.25 payable to: South Dakota Division of Criminal Investigation (DCI).
6. Your application will not be processed and/or temporary license will **not** be issued until your completed application **and** fingerprint cards are received.
7. You will **not** receive a permanent license until the fingerprint results from the Federal Bureau of Investigation (FBI) are received, approximately 1-2 weeks.
8. *Cards will be rejected if bent, folded, tampered with, stained, smeared or stapled. If rejected you will be notified to resubmit your cards.*

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### ☐ Request for Transcript Form

1. Complete Transcript Request Form 2 and send to the Office of the Registrar for each applicable college, university, or program which awarded you a graduate nursing degree or post graduate certificate which prepared you for your advanced nursing specialty role.
2. The transcript(s) must evidence the degree conferred and the date.
3. The official transcript(s) must be sent directly to the SD BON office from the college, university, or program. Copies of transcripts are not accepted.
4. Contact the Registrar's Office/Organization to determine the appropriate fee to enclose for transcript/document service.

### ☐ Education Verification

1. You complete applicant section of Education Verification Form 3; send a copy to each applicable college, university, or program from which you were awarded a graduate or post graduate certificate nursing degree.
2. The Dean/Director of the program, or designated official, completes remaining questions verifying education and accreditation status of the nursing program at the time of your attendance.
3. The Dean/Director of the program, or designated official, must return form to the SD BON office.

### ☐ Certification Verification

Primary source verification of *successfully passing a standardized qualifying certification examination* specific to your area of practice or evidence of *current certification* from a Board-approved certification organization is required for licensure and renewal in SD. Board-approved certification organizations include: Council on Certification of Nurse Anesthetists; American Association of Critical-Care Nurses (CCNS exam), American Nurses Credentialing Center, National Certification Corporation for OB, GYN & Neonatal Nursing Specialties. Contact the SD BON office regarding whether other certification organizations are accepted for licensure.

CNS applicant:

1. Complete top section of Certification Verification Form 4; forward to your certifying organization. Contact certifying organization to determine appropriate fee to enclose.
2. The certifying organization will return completed form directly (primary source) to the SD BON Office.
3. Please note, NCC and ANCC require requests for primary source verification via their websites.

CRNA applicant:

1. Primary source verification of certification status will be obtained online from the CCNA official website sponsored through the American Association of Nurse Anesthetists (AANA). Complete Form 4 and return to the BON office with application. You do not need to send Form 4 to CCNA/AANA.

### ☐ Temporary Permit

To practice as a CRNA or CNS in SD, you must possess a temporary permit or license issued by the BON authorizing your practice. A temporary permit is required before you can begin orientation at your place of employment. A temporary permit is valid only for the period of time it has been issued and may not be renewed. Practice beyond the expiration date is a violation of law and may result in disciplinary action. The holder of a temporary permit to practice will use the designation of **CRNA app.** or **CNS app.** after name.

1. A temporary permit by examination is issued to an applicant waiting for results of the first exam they are eligible to take after completion of an approved education program. The temporary permit will be issued when the following is completed and received in the Board office:
  - a. General Application – Form 1 with \$100 fee.
  - b. Temporary Permit Application – Form 5 with \$25 fee.
  - c. Verification of RN licensure: if you hold a "compact" RN license, other than SD, provide copy of license.
  - d. Verification of education: Letter from nursing education program Dean/Director verifying completion of all program requirements *and* eligibility to sit for a national certification exam specific to specialty. – OR – Transcript verifying degree was conferred.
  - e. Verification of examination eligibility: Documentation from certification organization that you are a

***Continues***

candidate for the exam. – OR – Documentation from certification organization that you are awaiting results of first exam for which you are eligible after graduation. – OR – Documentation from Dean/Director of nursing education program verifying eligibility to sit for a national certification exam specific to specialty.

- f. Fingerprint cards (*see Criminal Background Check above*)
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2. A temporary permit by endorsement is issued to an applicant who holds licensure as a CRNA or CNS in another state or territory and is awaiting licensure in South Dakota. The permit becomes invalid *90 days* from issuance date. The temporary permit will be issued when the following is completed and received in the SD BON office:
    - a. General Application – Form 1 with \$100 fee.
    - b. Temporary Permit Application – Form 5 with \$25 fee.
    - c. Verification of RN licensure: if you hold a “compact” RN license, other than SD, provide copy of license.
    - d. Verification of certification: Provide a copy of your current certification card from the certification organization – OR – Primary source verification of current certification on file with the Board sent by certification organization (See Form 4 below).
    - e. Verification of current licensure: Provide copy of current CRNA or CNS license from another state or territory.
    - f. Fingerprint cards (*see Criminal Background Check above*)



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**CERTIFIED REGISTERED NURSE ANESTHETIST & CLINICAL NURSE SPECIALIST  
GENERAL APPLICATION – FORM 1**

**Please Print**

1. Name, First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

1. Other names previously used: \_\_\_\_\_

2. Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Street/PO Box

3. Telephone: Home: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

5. US Citizen: ☐ Yes ☐ No Gender: ☐ Male ☐ Female

6. Ethnicity: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

7. Check title for which you seek licensure:

- ☐ *Certified Registered Nurse Anesthetist (CRNA)*
- ☐ *Clinical Nurse Specialist (CNS)*
  - ☐ Adult Health Nursing ☐ Gerontologic Nursing
  - ☐ Community Health Nursing ☐ Pediatric Nursing
  - ☐ Critical Care Nursing ☐ Diabetes
  - ☐ Psych-Mental Health Nursing
- ☐ Other: \_\_\_\_\_

8. Have you been licensed as a CRNA or CNS in another state? ☐ Yes (complete Question 8)  
☐ No (skip Question 8)

9. Advanced practice licensure history:

STATE	LICENSED AS	LICENSE #	DATE ISSUED	EXPIRATION DATE

10. Information regarding your professional nursing education that prepared you for nursing specialty:

INSTITUTION NAME	LOCATION (CITY, STATE)	COMPLETION DATE	PROGRAM TYPE
			<input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's
			<input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's
			<input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's

11. Do you hold current certification from a national certifying organization?  
☐ Yes (complete Question 11) ☐ No ☐ Awaiting results of certification exam from: \_\_\_\_\_  
Specialty: \_\_\_\_\_

12. Information regarding your certification from a national certifying organization:

CERTIFICATION ORGANIZATION	SPECIALTY	CERTIFICATION #	DATE ISSUED	EXPIRATION DATE

***Continues***

13. Declaration of primary state of residence:

I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is: _____ . This is my "home state" under the <u>Nurse Licensure Compact</u> and is my "declared fixed permanent and principal home for legal purposes." <p style="text-align: center;">- OR -</p> <input type="checkbox"/> I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____  RN License # in primary state of residence if other than South Dakota: _____  <div style="display: flex; justify-content: space-between;"> <span>_____ Applicant Signature</span> <span>_____ Date</span> </div>	
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14. If you hold a "compact" RN license, other than SD, provide copy of license.

15. Disciplinary Information:

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? <b>If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	Do you currently owe child support arrearages in the sum of \$1,000 or more?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.</b>			

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



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## TRANSCRIPT REQUEST – FORM 2

Applicant, please complete this form for each applicable college, university, or program that awarded you a graduate nursing degree or post graduate certificate which prepared you for your advanced nursing specialty role. Forward this form to the Office of the Registrar.

**Please Print**

1. Name, First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_
2. Other names previously used: \_\_\_\_\_
3. Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Street/PO Box
4. Date of Graduation: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I am requesting an official transcript (must bear raised or color coded school seal and evidence of the degree conferred and date conferred) of my nursing education be attached to this request and forwarded to the South Dakota Board of Nursing for licensure purposes.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**REGISTRAR:**

Please return this form with the official transcript and  
send to the South Dakota Board of Nursing at the address above.



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CERTIFIED REGISTERED NURSE ANESTHETIST & CLINICAL NURSE SPECIALIST  
EDUCATION VERIFICATION – FORM 3

**Applicant**, complete items 1 – 6 on this form then forward to the Dean/Director for each nursing college, university, or program which prepared you for your nursing specialty role.

**Please Print**

1. Graduate Name, First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_
2. Other names previously used: \_\_\_\_\_
3. Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Street/PO Box
4. Telephone: Home: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_ Email: \_\_\_\_\_
5. Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ I am submitting application for licensure as a:  
☐ CRNA ☐ CNS
6. Consent to *Release Information* to the South Dakota Board of Nursing:
  - I have applied to the South Dakota Board of Nursing for a license to practice. After I have completed all program requirements please complete this form and forward directly to the South Dakota Board of Nursing office for licensure purposes.

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_

**Program Director:** After completed forward to the South Dakota Board of Nursing at the address above.

7. University/Institution Name \_\_\_\_\_ Location (City, State) \_\_\_\_\_
8. Program Graduation/Completion Date: \_\_\_\_\_ at the time the Applicant graduated, the graduate nursing program was accredited by:
  - ☐ Council on Accred. Of Nurse Anesthesia Educational Programs
  - ☐ Commission on Collegiate Nursing Education
  - ☐ NLN/National League for Nursing Accrediting Commission ☐ Other: \_\_\_\_\_
9. Type of Program (check one): ☐ Certificate ☐ Master's Degree ☐ Post-Master's Certificate
10. Advanced role & specialty Applicant was educated in: ☐ CRNA or ☐ CNS (*complete questions below*)
  - Did the education program specifically prepare Applicant to function in the CNS role? ☐ YES ☐ NO
  - How was instruction completed?
    - ☐ Specific course work in CNS role development
    - ☐ CNS role development integrated throughout the curriculum
    - ☐ Other: \_\_\_\_\_
  - Did the CNS education program have a clinical practicum that provided for the integration of the areas of education, research, consultation, and leadership into the clinical role? ☐ YES ☐ NO
    - If NO, did the education program have a clinical component in the curriculum? ☐ YES ☐ NO

Dean/Director Signature *or* Other Designated Official/Title \_\_\_\_\_

Date \_\_\_\_\_

Place  
School  
Seal Here

If School Seal is no longer available, use either Agency/Institutional Seal, or so indicate.

07/28/2







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CERTIFIED REGISTERED NURSE ANESTHETIST & CLINICAL NURSE SPECIALIST  
TEMPORARY PERMIT APPLICATION – FORM 5

**Please Print**

1. Name, First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_
2. Check title for which you seek temporary permit:  
☐ CRNA – app.: *Certified Registered Nurse Anesthetist*  
☐ CNS – app.: *Clinical Nurse Specialist*
3. Check type of temporary permit you are requesting:

☐ I am requesting a **temporary permit by examination:**

NAME OF CERTIFICATION ORGANIZATION	EXAM SPECIALTY AREA	DATE EXAM WRITTEN – OR – DATE EXPECTED TO WRITE EXAM	DATE RESULTS EXPECTED

☐ I am requesting a **temporary permit by endorsement.** I currently hold a CRNA or CNS license in another state or territory.

4. List information about each facility where you will be practicing on this temporary permit:

NAME OF ORGANIZATION	ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)	TELEPHONE NUMBER(S)

I, the undersigned, declare and affirm under the penalties of perjury that this application for temporary permit in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**